Section 6

Coverage Requirements for Children's Health Insurance

Section 6. Coverage Requirements for Children's Health Insurance (Section 2103)

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 7.**

6.1. **The state elects to provide the following forms of coverage to children: (Check all that apply.)**

6.1.1 ☐ Benchmark coverage; (Section 2103(a)(1))

6.1.1.1. ☐ FEHBP-equivalent coverage; (Section 2103(b)(1)) (If checked, attach copy of the plan.)

6.1.1.2. ☐ State employee coverage; (Section 2103(b)(2)) (If checked, identify the plan and attach a copy of the benefits description.)

6.1.1.3. ☐ HMO with largest insured commercial enrollment (Section 2103(b)(3)) (If checked, identify the plan and attach a copy of the benefits description.)

6.1.2. ☐ Benchmark-equivalent coverage; (Section 2103(a)(2)) Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Please attach signed actuarial report that meets the requirements specified in Section 2103(c)(4). See instructions.

6.1.3. ☐ Existing Comprehensive State-Based Coverage; (Section 2103(a)(3)) [Only applicable to New York; Florida; Pennsylvania] Please attach a description of the benefits package, administration, date of enactment. If "existing comprehensive state-based coverage" is modified, please provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 state expenditures for **"existing comprehensive state-based coverage."**

6.1.4 ☒ Secretary-Approved Coverage. (Section 2103(a)(4))

Arizona will use ~~the least expensive state employees' HMO benefit package with the addition of dental and vision services. Please see Attachment K for a description of the benefits offered to state employees by Intergroup, which is the least expensive benefit package~~ the same benefits as are provided under the Medicaid State plan. Any limitations on the covered services are discussed in this section and will be

delineated in the ~~Office of the Medical Director's~~ AHCCCS Medical Policy Manual. The cost sharing requirements are specified in Section 8 of the State Plan.

~~The benchmark service package chosen by the state differs from the current AHCCCS package in two major areas: there will be no non-emergency transportation in the KidsCare Program and behavioral health services are limited to 30 days of inpatient services per year and 30 outpatient visits per year.~~ Members who enroll in the KidsCare Program who select an AHCCCS health plan or ~~one of~~ the state employee HMO~~s~~, if ~~any elect~~ the HMO elects to participate in the program, will receive the following KidsCare services, subject to the limitations described below:

The state elects to provide the following forms of coverage to children: (Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) **(Section 2110(a))**

6.2.1. ☒ Inpatient services (Section 2110(a)(1))

a. Inpatient hospital services, including medically necessary ancillary services, and emergency hospital services, if furnished by a licensed hospital and provided by or under the direction of a PCP or primary care practitioner according to federal and state law, rules, and AHCCCS Policies and Procedures. Inpatient hospital services include services provided in an institution specializing in the care and treatment of members with mental diseases.
b. Services in an Institution for Mental Diseases (IMD) when the member requires services in an inpatient psychiatric hospital. IMD are available to members who are determined to require these services after enrollment in KidsCare. ~~and are limited to 30 days per each 12 month period of eligibility~~. However, applicants in an IMD at the time of application are excluded from enrollment in KidsCare.
c. Medically necessary transplant services, which are not experimental, if provided to correct or ameliorate disabilities, physical illnesses or conditions. Transplantation services will be authorized in accordance with AHCCCS transplantation policies.

6.2.2. ☒ Outpatient services (Section 2110(a)(2))

Outpatient hospital services ordinarily provided in hospitals, clinics, offices and other health care facilities by licensed health care providers. Outpatient hospital services include

services provided by or under the direction of a PCP or primary care practitioner or licensed or certified behavioral health professional according to federal and state law. Certified behavioral health professionals include certified independent social workers, certified marriage/family therapists, and certified professional counselors.

6.2.3. ☒ Physician services (Section 2110(a)(3))

Physician services if provided by or under the direction of a PCP, psychiatrist, or under the direction of a primary care practitioner according to federal and state law. Services are covered whether furnished in the office, the member's home, a hospital, a nursing home or other setting.

Only psychiatrists, psychologists, certified psychiatric nurse practitioners, ~~and~~ physician assistants, certified independent social workers, certified marriage/family therapists, and certified professional counselors may bill independently for behavioral health services. Other behavioral health professionals, behavioral health technicians and behavioral health paraprofessionals shall be affiliated with~~,~~ an AHCCCS registered behavioral health agency and services shall be billed through that agency.

6.2.4. ☒ Surgical services (Section 2110(a)(4))

Medically necessary surgical services under inpatient and outpatient services (Sections 6.2.1 and 6.2.2).

6.2.5. ☒ Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))

a. Outpatient services (Section 6.2.2).
b. Ambulatory services offered by a health center receiving funds under section 330 of the Public Health Services Act.
c. Rural health clinic services and federally qualified health center services and other ambulatory services.

6.2.6. ☒ Prescription drugs (Section 2110(a)(6))

a. Pharmaceutical services provided to a member if prescribed by the attending physician, practitioner, or dentist.
b. Prescription drugs for covered transplantation services provided according to AHCCCS transplantation policies.
c. Generally, medications dispensed by a physician or dentist are not covered.

6.2.7. ☒ Over-the-counter medications (Section 2110(a)(7))

6.2.8. ☒ Laboratory and radiological services (Section 2110(a)(8))

Laboratory, radiological and medical imaging services.

6.2.9. ☒ Prenatal care and prepregnancy family services and supplies (Section 2110(a)(9))

a. The following family planning services:
   - Contraceptive counseling, medication, supplies and associated medical and laboratory exams
   - Natural family planning education or referral

b. Infertility services and reversal of surgically induced infertility are not covered services.

c. Family planning services do not include abortion or abortion counseling.

6.2.10. ☒ Inpatient mental health services, other than services described in 6.2.18, but including services furnished in a state-operated Medicare certified mental hospital and including residential or other 24-hour therapeutically planned structural services (Section 2110(a)(10))

~~a. Inpatient behavioral health services are limited to 30 days of inpatient care for each 12-month period of eligibility.~~

a. Inpatient behavioral health services, other than inpatient and residential substance abuse treatment services, but including services furnished in a state operated mental hospital and including residential or other 24-hour therapeutically planned structured services.

b. Services in a state operated mental hospital (e.g., Institution for Mental Diseases). IMD services are only available to members who are determined to require these services after enrollment. Applicants who are receiving IMD services at the time of application are excluded from enrollment in KidsCare.

c. Partial care services are included as part of the inpatient benefit. ~~and are subject to the 30 day limitation for each 12-month period of eligibility. If partial care services are provided the benefit is as follows: each half day partial care service will equal one-quarter inpatient day; each full day partial care service will equal one-half inpatient day.~~

6.2.11. ☒ Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a

state-operated mental hospital and including community-based services (Section 2110(a)(11)

~~a. All outpatient behavioral health services are limited to 30 visits per 12-month period of eligibility.~~

a. Outpatient behavioral health services, other than substance abuse treatment services, including services furnished in a state operated mental hospital (e.g., IMD) and community-based services.
b. Outpatient behavioral health services includes individual and/or group counseling/therapy, rehabilitation services, including basic and intensive partial care, emergency/crisis services, behavior management, psychosocial rehabilitation, evaluation and behavioral health related services.

6.2.12. ☒ Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) (Section 2110(a)(12))

See Section 6.2.17--Dental services for coverage of dental devices. ~~Eyeglasses are limited to one pair per each 12-month period of eligibility.~~ Vision Services include prescriptive lenses.

6.2.13. ☒ Disposable medical supplies (Section 2110(a)(13))

Disposable medical supplies include consumable items covered under Medicare that are not reusable.

6.2.14. ☐ Home and community-based health care services (See instructions) (Section 2110(a)(14))

6.2.15. ☒ Nursing care services (See instructions) (Section 2110(a)(15))

a. Private duty nursing care, respiratory care services, and services provided by certified nurse practitioners in a home or other setting.
b. Certified nurse midwife services when they are rendered in collaboration with a licensed physician or PCP or primary care practitioner in accordance with AHCCCS Policies and Procedures.

6.2.16. ☒ Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest (Section 2110(a)(16)

A physician shall provide written certification of necessity of abortion.

6.2.17. ☒ Dental services (Section 2110(a)(17))

a. Dental services, including routine, preventive, therapeutic and emergency services.
b. Dentures and dental devices are covered if authorized in consultation with a dentist.

6.2.18. ☒ Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18))

Inpatient substance abuse treatment is limited to acute detoxification.

6.2.19. ☒ Outpatient substance abuse treatment services (Section 2110(a)

a. Refer to coverage under 6.2.11 - Outpatient mental health services, subject to the limitations prescribed in that section.
b. Rehabilitation services provided by a substance abuse rehabilitation agency that do not exceed 30 outpatient visits for each 12-month period of eligibility.

6.2.20. ☒ Case management services (Section 2110(a)(20))

Case management for persons with developmental disabilities.

6.2.21. ☒ Care coordination services (Section 2110(a)(21))

Care coordination will be available through contractors, primary care providers and behavioral health providers.

6.2.22. ☒ Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))

Therapy services are covered when necessary to prevent or ameliorate a condition, illness or injury, to prevent or correct abnormalities detected by screening or diagnostic procedures or to maintain a level of ability.

6.2.23. ☒ Hospice care (Section 2110(a)(23))

Hospice services for a terminally ill member.

6.2.24. ☒ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) (Section 2110(a)(24))

a. Services provided in a facility, home, or other setting if recognized by state law.
b. Respiratory therapy
c. Eye examinations for prescriptive lenses ~~limited to one visit per year~~.
d. Immunizations, preventive health services, patient education, age and gender appropriate clinical screening test and periodic health exams.

6.2.25. ☐ Premiums for private health care insurance coverage (Section 2110(a)(25))

6.2.26. ☒ Medical transportation (Section 2110(a)(26))

Emergency ambulance and non-emergency transportation are covered services when the transportation is medically necessary. ~~if a medically necessary emergency exists. Non-emergency medically necessary transportation is not covered.~~

6.2.27. ☒ Enabling services (such as transportation, translation, and outreach services) (See instructions) (Section 2110(a)(27))

All printed materials will be in English and Spanish. Outreach services will be available through AHCCCS, and others as specified in Sections 4.4.4 and 5.

6.2.28. ☒ Any other health care services or items specified by the Secretary and not included under this section (Section 2110(a)(28))

1. Nursing facility services in a nursing facility or in an alternative residential setting for a maximum of 90 days when the medical condition of the person indicates that these services are necessary to prevent hospitalization.
2. Total parenteral nutrition services.
3. Podiatry services and optometrist services if furnished by a licensed podiatrist or optometrist, respectively.
4. Other practitioner's services are covered and include services provided by:
   a. Respiratory Therapists
   b. Certified Nurse Practitioners
   c. Certified Nurse Anesthetists
   d. Physician Assistants

e. Nonphysician behavioral health professionals if the services are provided by social workers, physician assistants, psychologists, counselors, registered nurses, certified nurse practitioners, behavioral health technicians and other approved therapists who meet all applicable state standards. Except for behavioral health services provided by psychologists, ~~or~~ psychiatric nurse practitioners, physician assistants, certified independent social workers, certified marriage/family therapists, and certified professional counselors, all nonphysician behavioral health professional services shall be provided by professionals affiliated with an approved behavioral health setting in accordance with rules and AHCCCS policies and procedures.

5. Home health services
   a. Home health services when necessary to prevent re-hospitalization or institutionalization, and may include home health nursing services, therapies, personal care, medical supplies, equipment and appliances and home health aide services.
   b. Nursing service and home health aide if provided on an intermittent or part time basis by a home health agency. When no home health agency exists, nursing services may be provided by a registered nurse.
   c. Therapy services.

Covered services are required to be authorized by the appropriate entity, unless otherwise indicated. Authorization by an appropriate entity shall be performed by at least one of the following: a PCP, primary care practitioner, or behavioral health professional as required by rule and AHCCCS policies and procedures. The appropriate entity shall authorize medically necessary services in compliance with applicable federal and state laws and regulations, AHCCCS policies and procedures and other applicable guidelines.

6.3. Waivers - Additional Purchase Options. If the state wishes to provide services under the plan through cost effective alternatives or the purchase of family coverage, it shall request the appropriate waiver. Review and approval of the waiver application(s) will be distinct from the state plan approval process. To be approved, the state shall address the following: (Section 2105(c)(2) and (3))

6.3.1. ☐ Cost Effective Alternatives. Payment may be made to a state in excess of the 10% limitation on use of funds for payments for: 1) other child health assistance for targeted low-income children; 2) expenditures for

health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); 3) expenditures for outreach activities as provided in section 2102(c)(1) under the plan; and 4) other reasonable costs incurred by the state to administer the plan, if it demonstrates the following:

6.3.1.1. Coverage provided to targeted low-income children through such expenditures shall meet the coverage requirements above. Describe the coverage provided by the alternative delivery system. The state may cross reference section 6.2.1 - 6.2.28. (Section 2105(c)(2)(B)(i))

6.3.1.2. The cost of such coverage shall not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the coverage described above. Describe the cost of such coverage on an average per child basis. (Section 2105(c)(2)(B)(ii))

6.3.1.3. The coverage shall be provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under section 1886(d)(5)(F) or 1923 of the Social Security Act. Describe the community based delivery system. (Section 2105(c)(2)(B)(iii))

6.3.2. ☐ Purchase of Family Coverage. Describe the plan to provide family coverage. Payment may be made to a state for the purpose of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children, if it demonstrates the following: (Section 2105(c)(3))

6.3.2.1. Purchase of family coverage is cost-effective relative to the amounts that the state would have paid to obtain comparable coverage only of the targeted low-income children involved and describe the associated costs for purchasing the family coverage relative to the coverage for the low income children. (Section 2105(c)(3)(A))

6.3.2.2. The state assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. (Section 2105(c)(3)(B))